NOTE ON ACUTE PERIOSTITIS OF FEMUR IN CHILDREN.

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CASE. On Feb. 25, 1890, a boy, æt. 11, was admitted from Hendon with a history that ten days previously he had felt pain near the left knee, which, on the following morning, was so severe that he had to keep in bed. Two days later the thigh began to swell and he had a "shivering attack." The pain steadily increased, he lost his appetite and he complained of severe headache.

On his admission into the hospital the lower end of the femur was enlarged and very tender, and the boy could not bear to have it touched. The skin over that part was flushed and hot. There was no fluid in the knee-joint The axillary temperature was 101.8. Boracic fermentations were applied and the limb was raised on a pillow.

Next morning Mr. Owen saw the boy and at once ordered an incision to be made down to the femur upon the outer side through the space between the ilio-tibial band and the tendon of the biceps. The operation was performed after the method of Hilton, and a large subperiosteal abscess was evacuated, the bone being found bare over a considerable extent. The cavity was then thoroughly irrigated with hot carbolic lotion, 1 in 40. The temperature, which before the operation was 102.8, descended shortly to the normal line. On the evening of the fourth day it again mounted to 101°, but after that it scarcely departed from normal. Provision was made for drainage, the wound was dressed with mercuric gauze, and the limb was fixed on a back splint. Iron and quinine were prescribed, and some port-wine was ordered. After the tension had been thus relieved the boy began to sleep well, and his appetite returned; he greatly improved in aspect, and he left the hospital well and strong toward the end of May. No necrosis occurred.

REMARKS.

The lower end of the femur is a favorite region for acute periostitis in children. The disease is usually marked by great constitutional disturbance—often with delirium, there is, on comparing the two sides, a deep-seated, central thickening. Treatment must be prompt; there should be no dallying with opium, salicylic acid, evaporating lotions, fomentations or leeches.

Nor should the practitioner wait for "fluctuation" before using the knife. A clean-handed surgeon should not hesitate to cut down at once on to the swollen femur; traversing the anatomical space indicated above, he will reach the bone without danger or difficulty. Delay, on the other hand, entails many and great dangers: pyæmia, necrosis, chronic suppuration, hectic, albuminoid disease, destruction of the knee-joint. Hesitation and irresolution in the case of periostitis of the femur have many a time involved the surgeon in using the amputating knife instead of the scalpel, or have condemned the child to endure an agonizing pain which has ended in delirium and death. My experience in some of these desperate cases has been that the practitioner has had too much of the mind of Macbeth, who argued with himself when about to use the trenchant blade: "If it were done, when 'tis done, then 'twere well.

"It were done quickly." He knew what he wanted to do, but he had not the courage of his opinions. "Infirm of purpose!" said his clear-headed spouse, "Give me the daggers." In dealing with acute periostitis in children more of the spirit of Lady Macbeth is needed.